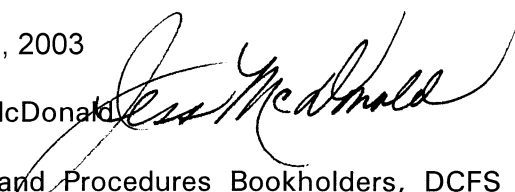


DEPARTMENT OF CHILDREN AND FAMILY SERVICES

DISTRIBUTION: X and Z

POLICY GUIDE 2003.05

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
(HIPAA)**

DATE: April 11, 2003
FROM: Jess McDonald 
TO: Rules and Procedures Bookholders, DCFS and Purchase of Service (POS) Staff
EFFECTIVE DATE: April 14, 2003

I. PURPOSE

The purpose of this Policy Guide is to describe the federal Health Insurance Portability and Accountability Act (HIPAA) and how it affects the Department.

II. PRIMARY USERS

The primary users of this (HIPAA) Policy Guide are all DCFS staff that use and/or disclose health information regarding DCFS clients and wards. This information is being provided to assist staff in becoming more familiar with HIPAA and how the Department has determined it specifically relates to DCFS clients and wards. POS agencies are responsible for adhering to this Policy Guide, pursuant to Section H, part 2 of the POS contract with DCFS, as this information relates to DCFS. However, POS agencies should independently seek guidance and legal advice from their own private sources on HIPAA compliance issues that apply to their agencies.

III. WHAT IS HIPAA

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which amends the Internal Revenue Service Code of 1986 which includes a section on Administrative Simplification requiring the following:

- 1) Improved efficiency in healthcare delivery by standardizing electronic data interchange that includes standardization of electronic patient health, administrative, and financial data and unique identifiers for individuals, employers, health plans and health care providers.



- 2) Protection of confidentiality and security of health data through setting and enforcing standards that protect the confidentiality and integrity of "individually identifiable health information."

IV. HOW DOES HIPAA AFFECT THE DEPARTMENT

HIPAA only applies to "covered entities" defined under the regulations. The Department is deemed a "covered entity" for its Comprehensive Medicaid Billing System (CMBS) and Medicaid Billing System (MBS) functions and activities. Because of this, the Department has assessed the impact of the privacy regulations as described below. For additional information specific to CMBS/MBS and related requirements, please see Policy Guide 2003.04

V. HIPAA PRIVACY STANDARDS

HIPAA Privacy standards carry out the following:

- Limit the non-consensual use and release of private health information
 - Give patients new rights to access their medical records and to know who else has accessed them
 - Restrict most disclosure of health information to the minimum needed for the intended purpose
 - Establish new criminal and civil sanctions for improper use or disclosure
 - Establish new requirements for access to records by researchers and others
- 1) Although the federal regulations establish consistent standards for handling medical, alcohol and other drug abuse, and mental health information, there should be no conflict between the Department's rules on what health information it has a right to obtain on behalf of wards or what information it may disclose. **Rule and Procedures 327, Guardianship Services and, 431, Confidentiality of Personal Information of Persons Served by the Department**, are still fully applicable under HIPAA. Further, the Guardianship Administrator and authorized agents meet the definition of a personal representative under HIPAA (see #4 below).
 - 2) When conflicts do arise between the HIPAA and other confidentiality rules, including the federal Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2), the stricter requirements apply.
 - 3) The HIPAA regulations do not prohibit the reporting of suspected child abuse or neglect by covered entities. Mandated Reporter requirements are still in effect for covered entities.

- 4) HIPAA does allow the release of personal health information to an individual's personal representative. Included in the definition of personal representative is a guardian or person acting in loco parentis with legal authority to make health care decisions on behalf of a minor child. When mental health, alcohol and other drug abuse patient records are requested to be released, written consent by the patient is required for children age 12 and older.
- 5) If Department, POS or HealthWorks staff experience difficulty in obtaining information to which the Department has a right from health providers who cite HIPAA as a reason to deny information, staff should first consult with their authorized agent who, in turn, will consult with the Guardianship Administrator if the problem persists.
- 6) Attached for your reference are the following consent forms. These forms have been updated to clarify and address HIPAA-related issues.

CFS 415, Consent for Ordinary and Routine Medical and Dental Care;

CFS 431, Consent of Guardian to Medical/Surgical Treatment;

CFS 431-1, Consent of Guardian to Mental Health/Rehabilitative Services Assessment;

CFS 439A, Consent for Release of Mental Health Information

CFS 440-7, Consent for Disclosure - Substance Abuse Assessment and/or Treatment; and

CFS 600-3, Consent for Release of Information;

Caseworkers should keep a copy of the Dispositional Order ready when requesting health information in case a health provider requests proof that DCFS has the legal right to authorize disclosure for the child or youth.

VI. DISCLOSING INFORMATION FOR HEALTHWORKS PURPOSES

For the Department's purposes, HealthWorks is not a covered function as defined under HIPAA. HealthWorks functions to fulfill a legally mandated role to arrange for health care services for clients in custody or who are wards. HealthWorks Lead Agencies and their medical case management agencies are authorized to receive medical information on children in custody or for children who are DCFS wards, and can use consents signed by the Guardianship Administrator or an authorized agent to obtain information from health providers.

Caseworkers should provide their local HealthWorks Lead Agency and medical case management agency with a copy of the Dispositional Order so that this information can be maintained on file in case a health provider requests proof that DCFS has the legal right to authorize disclosure for the child or youth.

VII. DISCLOSING INFORMATION FOR REGULATORY REVIEW PURPOSES

Under HIPAA, covered entities may disclose protected health information for health oversight activities required by law. The Department's health oversight activities include state-run compliance reviews such as Medicaid Part 132 reviews, Agency Performance Team reviews, Independent Utilization Reviews, and Licensing reviews. Health oversight activities include a broad range of civil, administrative, or criminal investigations or proceedings.

VIII. CONTACT PERSONS

If there is a question about whether a particular disclosure is appropriate, contact the DCFS Office of Legal Services at 312/814-2401.

For transaction code sets or other technical information, contact Bob Laurent at 217-524-2411.

For questions about HIPAA in general and/or the Department's Compliance Plan, contact Stephanie Hanko, HIPAA Project Manager, at 217/785-0250.

IX. FILING INSTRUCTIONS

File this Policy Guide with Procedures 431, Confidentiality of Personal Information of Persons Served by the Department of Children and Family Services.

CONSENT FOR ORDINARY AND ROUTINE MEDICAL AND DENTAL CARE

As custodian/guardian for _____, birthdate, _____, I am authorized to act, pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, on behalf of the individual minor and I hereby consent to the administration of ordinary and routine medical and/or dental care to this child by:

Name: _____

Address: _____

Telephone: _____

Ordinary and routine medical and/or dental care includes, but is not limited to, physical and dental examinations, remedial treatment for minor illnesses, immunizations and related diagnostics laboratory tests, including HIV testing per the guidelines on reverse side of this form.

This consent is not valid for hospital admissions, surgery, anesthesia, blood transfusions, tooth extractions, the administration of psychotropic medications or related HIV treatment.

Consent for treatments other than that which are described as ordinary and routine can be obtained Monday through Friday at the number listed below.

Consents for other treatments can be obtained during weekends, holidays and after regular office hours by calling 773-989-3450 or 217-782-6533.

This consent is valid until _____.

I further consent that the above-named care provider may release and furnish to any DCFS employee both written and verbal reports concerning services provided to the above-mentioned child pursuant to this consent. I am authorized to use and disclose health information concerning the minor, as the minor's personal representative, as defined by HIPAA, 45 CFR 164.502(g),

DCFS Guardianship Administrator

Date _____

by _____
Authorized Agent

Address _____

Signature of Client 12 Years and Over

Telephone _____

DCFS HIV TESTING GUIDELINES

Risk factors for testing for HIV include:

1. HIV related symptoms.
2. a child born to a parent with HIV.
3. a child born to a parent at risk for HIV.
4. a child who was sexually penetrated by a person with a history of drug use, transfusions, or homosexual or bisexual relations.
5. a child born with positive drug toxicology.
6. a child with hemophilia or a history of blood transfusions prior to 1985.
7. a youth with a history of drug use.
8. a youth who is sexually active.

Please report all testing results to the DCFS Authorized Agent who signed the consent contained on the reverse of this form.

State of Illinois
Department of Children and Family Services

CONSENT OF GUARDIAN TO MEDICAL/SURGICAL TREATMENT

As the legal custodian/guardian of _____ a minor,
whose birthdate is _____, I am authorized to act, pursuant to 705 ILCS 405/2-11
or 705 ILCS 405/2-27, on behalf of the individual minor in making health care related decisions, and I
hereby consent to and authorize all:

☐ medical care

☐ dental care

☐ surgical care

☐ hospital admission/care

☐ administration of anesthetics

☐ local

☐ general

☐ conscious sedation

☐ administration of blood

as may be required with regard to the following procedure or condition _____

It is understood that these medical and/or surgical or treatment procedures are recommended by
Dr. _____, whose
address is _____, and that
these procedures will take place on or about _____, _____,
at _____
(hospital, clinic, or office and address, and phone)

THE ABOVE CONSENT IS SUBJECT TO THE FOLLOWING SPECIAL CONDITIONS:

I further consent that the physician, dentist, hospital, or clinic named above may release and furnish to
_____ M.D. or to any social worker employed by the
Department of Children and Family Services any and all information, both written and verbal concerning
medical, dental, surgical, psychological, or psychiatric treatment or evaluation regarding the above-named
minor word. I am authorized to use and disclose health information concerning the minor, as the minor's
personal representative as defined by HIPAA, 45 CFR 164.502(g).

Date _____

Guardianship Administrator

Witness _____

by _____
(Asst. Guardianship Administrator and Authorized Agent)

Address _____

cc: _____
(Service Office)

Telephone: _____
(8:30 a.m.-5:00 p.m.)

(Evenings, Weekends, Holidays)

PHYSICIAN'S STATEMENT CONCERNING RECOMMENDED MEDICAL/SURGICAL PROCEDURE

Patient's Name: _____ Date of Birth: _____

I. Recommended Elective Procedure (description and correct terminology):

Name and Address of Hospital or Clinic (where procedure will be performed):

Date Scheduled _____

II. Diagnosis and Description of Current Problem: _____

III. Statement of Patient's General Health (include major illnesses in the past, surgical procedures, chronic illnesses, bleeding problems, allergies, chronic administration of medication, any condition which might influence surgical risk or recovery, etc): _____

Name of Physician: _____

Date: _____

Address: _____

Phone No. _____

State of Illinois
Department of Children and Family Services

**CONSENT OF GUARDIAN TO MENTAL HEALTH/
REHABILITATIVE SERVICES ASSESSMENT**

As the legal custodian/guardian of _____,
a minor whose birthdate is _____, I am authorized to act, pursuant to 705
ILCS 405/2-11 or 705 ILCS 405/2-27, on behalf of the individual minor, and I hereby consent to an
assessment to determine the need for mental health services in accordance with 59 Ill. Admin. Code, Part
132, Medicaid Community Mental Health Services Program. It is understood that such assessment will take
place on or about _____, 20_____, at _____

(Agency and address and telephone number)

THE ABOVE CONSENT IS VALID UNTIL _____

AND IS SUBJECT TO THE FOLLOWING SPECIAL CONDITIONS: _____

I further consent that the agency named above may release and furnish to _____

_____ or to any social worker employed by the Department of Children
and Family Services any and all information, both written and verbal concerning the mental
health/rehabilitative assessment or treatment regarding the above-named minor ward. As the legal
guardian/custodian, I am the legal representative of the individual minor, as defined by HIPAA, 45 CFR
164.502(g). I have the right, on behalf of the minor, to revoke this authorization in writing prior to the
expiration date. Further disclosure may not occur without express written authorization. NOTE: THE
CONSENT OF MINORS OVER 12 YEARS OF AGE IS ALSO REQUIRED PRIOR TO THE RELEASE OF
ANY MENTAL HEALTH INFORMATION.

Date _____

Guardianship Administrator

Witness _____

by _____
Asst. Guardianship Administrator
or Authorized Agent

Address _____

cc: _____
(Service Office)

Telephone _____
(8:30 a.m.-5:00 p.m.)

(Evenings, Weekends, Holidays)

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State of Illinois
Department of Children and Family Services

CONSENT FOR RELEASE OF MENTAL HEALTH INFORMATION

I, _____, Guardianship Administrator for the Illinois Department of Children and Family Services, have been appointed the legal guardian or custodian of the minor, _____, pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, and I hereby authorize _____
(Name of Facility)

to release all mental health information, including notices regarding restriction of rights, concerning

(Name of Minor)

(Birth date)

to attorneys from Legal Advocacy Services (LAS) for the purpose of LAS providing individual legal representation of the minor's interest while hospitalized. This information may not be redisclosed without written and proper consent. I am acting as the minor's personal representative, as defined by HIPAA, 45 CFR 164.502(g), in giving this limited authorization for the release of mental health information. I retain the right, on behalf of the minor, to revoke this authorization in writing prior to the expiration date. Otherwise, this authorization is valid until the minor is released from the facility or until

(Date)

Guardianship Administrator

BY: _____

Authorized Agent

SIGNED: _____
(Signature of person 12 years or older for release
of his/her mental health records)

DATE: _____

Distribution:

One copy to Service Provider

One copy to: Case Record

One copy to: Guardianship Administrator

One copy to: Child (if 12 years and older)

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CONSENT FOR DISCLOSURE -- SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT

I, _____, whose birthdate is _____, and whose
(Name of client) (Birthdate)
Social Security Number is _____, hereby authorize:
(Social Security Number)

The Department of Human Services and/or _____
(AOD service program or agency name)

AND

The Department of Children and Family Services and/or _____
(Private child welfare agency name)

to provide between each other the following information (*Client and/or guardian must initial the applicable information to be disclosed*):

- | | |
|--|---|
| <input type="checkbox"/> Identifying information, including legal name, date of birth and SSN | <input type="checkbox"/> Information about attendance at assessment interview |
| <input type="checkbox"/> Information about substance abuse history | <input type="checkbox"/> Notification of upcoming court hearings, case reviews, etc. to allow preparation of status reports |
| <input type="checkbox"/> Information about treatment attendance, placement, and progress | <input type="checkbox"/> Information about parent-child interactions observed during the treatment process |
| <input type="checkbox"/> Copy of client's portion of the Individualized Client Service Plan and Social History | <input type="checkbox"/> Re-disclosure of information on substance abuse history and treatment progress to the responsible Juvenile Court entities, including Judge, State's Attorney, Public Guardian, and Public Defender |

I understand that this exchange of information is necessary to complete my referral for needed services and for obtaining updates regarding my attendance at and progress in treatment. I understand that I may revoke this consent at any time, except to the extent that the disclosure agreed to has been acted on. I understand that I have the right to inspect and copy the information to be disclosed. If not previously revoked, this consent will terminate when any of the following conditions have been met: 1 year from the date of this signature or 30 days following discharge from treatment (which ever is later) or other date, event, or condition
(as specified): _____

It has been explained to me that if I refuse to consent to this disclosure, the Department (or private child welfare agency, where applicable) or court entity cannot receive information regarding my progress that may affect the child welfare decisions made regarding my family's case.

☐ Check here if client refuses to sign the consent.

Signature of Client

Date

I, _____, the Parent, or the Legal Guardian or Custodian, appointed pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, am authorized to act on behalf of the minor, _____, and I hereby consent to this limited disclosure under the terms stated above. The legal guardian or custodian or parent is the legal representative of the unemancipated minor, pursuant to HIPAA, 45 CFR 164.502(g), unless otherwise required by law.

Signature of Parent, Guardian, or Authorized Representative

Date

Signature of Witness

Date

NOTICE TO RECEIVING AGENCY OR PERSON: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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CONSENT FOR RELEASE OF INFORMATION

1. I, _____, hereby give consent to:
2. _____
(Provider of Information) (Address)
3. to release information concerning _____ b.d. _____
4. to: _____
(Address)
5. Medical (specify): _____

6. Mental Health (specify): _____

7. Education: _____
8. Social History/Assessment (specify): _____
9. Financial (specify): _____
10. Other (specify): _____
11. THE PURPOSE FOR REQUESTING THIS INFORMATION IS: _____

12. I UNDERSTAND THAT IF I REFUSE TO CONSENT, THE FOLLOWING MAY HAPPEN: _____

I understand that I have the right to inspect and copy the information disclosed, except for certain adoption records, certain information regarding the identity of a source of information or the location of the child, or under certain circumstances where information was received from a minor under a promise of confidentiality.

I understand that I may revoke this consent at any time by notifying _____ in writing. I also understand that, even if I do not revoke this consent, the consent will expire one year from the date provided on line 13 below. A revocation will not affect information previously disclosed.

13. _____
Date
14. _____
Signature of Consenting Party
15. _____
Signature of Minor (Age 12-17)
16. _____
Address of Consenting Party
17. I, _____, the Parent, or the Legal Guardian or Custodian, appointed pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, am authorized to act on behalf of the minor, _____, and I hereby consent to this limited disclosure under the terms stated above. The legal guardian or custodian or parent is the legal representative of the unemancipated minor, pursuant to HIPAA, 45 CFR 164.502(g), unless otherwise required by law.
18. _____
Signature of Parent, Guardian, or Authorized Representative
- _____
Date
19. _____
Signature of Witness

REDISCLOSURE CONSENT: The information to be disclosed is confidential and is provided only to the party specified in the above consent. The receiving party cannot redisclose the information, with the exception of reports and other information that is required to be released to the court and certain parties to juvenile court proceedings as delineated in the Juvenile Court Act, 705 ILCS 405 and to

(if none other, enter "none other").

Signature of Consenting Party

Date

Signature of Minor (Age 12-17)

Date.

See reverse side of form for instructions

INSTRUCTIONS FOR COMPLETING THE CFS 600-3

- Line 1:** Enter the name of the person giving consent.
- Line 2:** Enter the name and address of the facility or person that is the custodian of the information requested. It may be necessary to prepare a consent form for each provider if there are multiple providers with medical, mental health or substance abuse records that need to be released.
- Line 3:** Enter the name and date of birth of the person whose records or information will be released. Prepare a separate consent form for each person whose records are to be released.
- Line 4:** Enter the name and address of the agency or person to which the information will be released. Do not use specific names to avoid problems in the event of case transfers, job changes, etc. If it will be necessary to share the information beyond DCFS, the private agency or contractor, the Redislosure Consent section at the bottom of the form must be completed. Without consent for redislosure it may be necessary to prepare additional consent forms to authorize redislosure.
- Lines 5-10:** Enter the specific type of information to be released. Include relevant years of treatment/services. The law prohibits blanket consents. The consent should cover all documents **relevant** to the purpose for which the information is requested. You do not need to know of the existence of a particular document to request it. There should be a correlation between the type of information requested and the reason(s) for the request entered on line five. For example, if the purpose for the request is to assess parenting capabilities, the information requested must relate to the individual's ability to function or to parent, which may include therapist's notes, reports or other mental health information.
- Line 11:** Enter the reason for requesting the information. Frequently used reasons include:
- casework planning;
 - provision of social services;
 - evaluation for purposes of service planning/placement/licensing decisions;
 - assessment of parenting capabilities;
 - to assess progress in treatment;
 - to assist in determining whether abuse or neglect occurred;
 - to assess safety risks or identify risk factors that could impair the child's safety;
 - to determine prognosis for change; and
 - to determine appropriate visitation.
- Line 12:** Enter the consequences that will be imposed by the Department if the person refuses to consent. Such consequences may include:
- worker may attempt to screen case into court;
 - worker may seek a court order for disclosure;
 - worker may recommend to the court that the child be removed;
 - worker may be unable to recommend expanded visitation to the court;
 - visitation may be denied or delayed;
 - reunification may be denied or delayed;
 - the Department will be unable to assess for provision of services;
 - the Department may weigh failure to consent in determining whether the parent is compliant with services or has completed tasks satisfactorily;
 - the Department may make adverse decisions concerning foster children in your care; or
 - any other valid consequence.
- Workers may not suggest or imply adverse consequences to clients beyond those that the Department can actually impose. In addition, no adverse consequence would flow from failure to consent unless the information sought is reasonably needed by the Department in fulfillment of legitimate departmental functions (i.e., investigating abuse or neglect allegations, providing follow-up services, determining appropriate placement or permanency goal, supporting termination of parental rights or licensure).
- Line 13:** Enter the date the consent form is signed. The consent will expire one year from the date signed.
- Line 14:** After all sections of the form have been completed, have the appropriate person sign the form. If the records are for an adult, the adult should sign. If the records of a child (age 11 and under) are sought, the parent or guardian should sign. If the child is a ward, the Guardian of the Department should sign the form.
- Line 15:** Children 12 years of age or older are required to sign the consent in addition to their parent or guardian when their mental health information and information regarding birth control services, pregnancy, treatment for sexually transmissible diseases or drug or alcohol abuse treatment is requested.
- If a Department ward is age 18 or over and has not been declared incompetent by a court of law, only the ward may consent to release of his/her personal information.
- Line 16:** Enter the address of the consenting party.
- Line 17 - 18:** Enter the signature and relationship of the person giving consent to the person whose information is requested.
- Line 19:** A witness who is familiar with the person giving consent must sign the consent form when mental health information is requested. The witness should be someone other than the worker.

Redislosure Consent: This section must be completed when the information will be shared with persons outside of the Department or private agency or contractor named on line 4. For information referenced in line 15 of the instructions, the same procedures must be followed for redislosure.